

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 8, 2019

Ms. Jeana Lavallee, Manager Living Well Residence 71 Maple Street Bristol, VT 05443-1004

Dear Ms. Lavallee:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **July 16, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

famila MCotaRN

Licensing Chief

PRINTED: 07/19/2019 FORM APPROVED

Division of Licensing and Pro STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
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		0543	B. WING		07/16/2019
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE	6
LIVING W	ELL RESIDENCE		.E STREET L, VT 05443		
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R100	Initial Comments:	ar 2	R100		
	was conducted by	ous complaint investigation the Division of Licensing and and 7/16/19. There were	,		
R128 SS=D	V. RESIDENT CAR	RE AND HOME SERVICES	R128	·	
	5.5 General Care			(i)	
		nt's medication, treatment, and all be consistent with the			
				R128:	¥
	This REQUIREME by:	NT is not met as evidenced	19	11120	×
	facility failed to instadministration was	rview and record review, the ure that medication consistent with the physician! sidents, Resident #1. Finding		and all med techs be message system av QuickMar (electronic will be communicate	MAR). All new orders d by the nurse or
	by the facility's Regard an order for Le (milligrams) was g	ccompanied to the physician gistered Nurse (RN) on 6/24/1 evaquin 500 mg by mouth dail iven to the nurse, secondary to	y	House Manager via system. Any messge or instructions about changes will require	message through this e containing information t new orders or med a response to the
9	and refusing hospi an interview with the Levaquin was to be She further stated	diagnosed with pneumonia talization at the time. During ne RN, s/he stated that the estarted as soon as possible. I that the prescription was faxend spoke with the medication	ed	any employees next This is how we will all med techs are av	ninutes after the start o scheduled shift. ensure that vare of new orders and
	technician (med te notification for the with the house ma on duty signed for administer it. The	ch) that was on duty and left evening staff. Per interview nager, the med tech that was the Levaquin, but did not med tech stated that s/he was because of the notification		in that, the nurse will received a response	monitoring for success I know if she has not from the med tech eframe. She will then

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Division	of Licensing and Pro	otection			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
		0543	B. WING		C 07/16/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
LIVING WELL RESIDENCE 71 MAPLE STREET BRISTOL, VT 05443					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
R128	Continued From pa	ge 1	R128		
R15: SS≏D	from the RN, but did not question why it was crossed out on the electronic MAR. The house manager confirmed at 3:55 PM on 7/16/19 that the med tech should have administered the medication per order and that education needed to be provided to the med tech regarding following physician orders. 5 V. RESIDENT CARE AND HOME SERVICES R155			Nurse provided additional one on one education to the Med Tech on 7/19/19 and 7/26/19 regarding both receiving meds from the pharmacy and physician orders. As of 07/19/19 all Med Techs were instructed to call Nurse or House Manager for clarification in the event that any order appears greyed out, which is indicative of an error. Discontinued orders appear with a yellow flag.	
	5.9.c. (12)			a joint hag.	

Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the Nurse failed to insure that staff performed the administration of medication in accordance with the home's policies for 1 of 3 residents, Resident #1. Findings include:

Resident #1 was accompanied to the physician by the facility's Registered Nurse (RN) on 6/24/19 and an order for Levaquin 500 mg by mouth daily (milligrams) was given to the nurse, secondary to Resident #1 being diagnoses with pneumonia. During an interview with the RN, s/he stated that the physician wanted the resident to be hospitalized, but due to resident refusal Levaquin was to be started as soon as possible. The evening medication tech confirmed on 7/16/19 that s/he did not give the medication and did not question why it was ordered but was grayed out on the Medication Administration Record, which

R155:

Beginning 07/19/19 the House Manager, RN, and all Med Techs began using the built in message system available through QuickMar (electronic MAR). All new orders will be communicated by the Nurse or House Manager via message through this system. Any message containing information or instructions about new orders or med changes will require a response to the sender aknowledging receipt of the message within ten minutes after the start of any employees next scheduled shift. This is how we will ensure that all med techs are aware of new orders or special instructions. This system also provides immediate monitoring for success in that, the nurse will know that she has not received a response from the med tech within the stated timeframe. She will then follow up with a phone call. The Nurse provided additional one on one education to the Med Tech on 7/19/19 and 7/26/19

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LIVING WELL RESIDENCE		E STREET ., VT 05443						
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Registered Nurse sexpectation that the orders of the physical stated on 7/16/19 awould need to be not seen to be not seen as the seen to be not seen as the seen are seen as the	age 2 s discontinued. The stated that it was the emedication be given per the cian. The house manager at 3:55 PM that the med tech e-trained about the policies of stration per the physician	R155	regarding both receiving metal pharmacy and physician of 07/19/19 all Med Techs we call Nurse or House Mana clarification in the event the appears greyed out, which an error. Discontinued ord a yellow flag.	rders. As of ere instructed to ger for at any order is indicative of				
5.10 Medication 5.10.b The manag for ensuring that al according to the he designated staff ar and procedures. This REQUIREME by: Based on staff inte Manager failed to i handled according three residents, Re Resident #1 was a by the facility's Reg and an order for Le (milligrams) was gi the resident having refusal to being ad time. During an int stated that the Lev- soon as possible.	RE AND HOME SERVICES Management er of the home is responsible I medications are handled one's policies and that a fully trained in the policies NT is not met as evidenced exiew and record review, the insure that medications were to home policies for one of exident #1. Findings include: ccompanied to the physician pistered Nurse (RN) on 6/24/19 exaquin 500 mg by mouth daily wen to the nurse, secondary to a diagnosis of pneumonia and mitted to the hospital at this erview with the RN, s/he aquin was to be started as The evening medication tech 19 that s/he did not give the		R161: Beginning 7/19/19 the Houland all Med Techs began of message system available QuickMar (electronic MAR) will be communicated by the House Manager via message system. Any message contoor instructions about new of changes will require a responder aknowledging received we will ensure that all Med of new orders or special insurance of the memory of	sing the built in through . All new orders e Nurse or ge through this aining information rders or med onse to the pt of the message start of any shift. This is how Techs are aware structions. This ediate monitoring se will know if conse from the timeframe. She none call. The one on one on 7/19/19 and g meds from the ders. As of e instructed to call				

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discontinued. The was the expectation per the orders of the manager stated on med tech would ne policies of medication physician orders. The manager of the medical administered until the hospital that stated	ord, which indicates that it was Registered Nurse stated that it in that the medication be given e physician. The house 7/16/19 at 3:55 PM that the ed to be re-trained about the ion administration per the The house manager was	8	Attached please find letter from Nurse.	of clarification		
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Points of Clarification

7/30/19

The surveyor called me on my cell phone and it was not a clear connection. I was at another place of work and could not hear well. To clarify, the physician did not say "as soon as possible" nor was this written on the order. The Nurse told the pharmacy to deliver the med as soon as possible.

To clarify the statement that the resident refused hospital care, she did not refuse. She was offered the choice of treatment in the hospital or at home. She chose to be treated in her home (Living Well Residence).

The Nurse and House Manager will schedule a meeting with Wilcox pharmacy to again discuss this specific issue and how errored orders can be prevented or communicated.

Thank you,

Dorothy Delaney RN

Living Well Residence